Montana Department of Public Health and Human Services

West Nile Viral Illness Reporting Form

PATIENT INFORMATION

Name:			DOB:
Age:	Sex: ~ M ~ F	Race: ~ White ~ Black ~ American Indian ~ Asian ~ Hispanic ~ Unk	
Address:			Phone:
City:	County:		Zip:

CLINICAL INFORMATION

Date of Illness Onset:	**Neuro-invasive Illness:** **~ Yes ~ No ~ Unk**	**Febrile Illness:** **~ Yes ~ No ~ Unk**
Hospitalized: ~ Yes ~ No	Encephalitis: ~ Yes ~ No ~ Unk	Fever ($38EC or100EF): ~ Yes ~ No ~ Unk
Hospital Name:	Meningitis: ~ Yes ~ No ~ Unk	Muscle Weakness: ~ Yes ~ No ~ Unk
Date of Admission:	Stiff neck/Meningeal signs: ~ Yes ~ No ~ Unk	Headache: ~ Yes ~ No ~ Unk
Discharge Date:	Seizures: ~ Yes ~ No ~ Unk	Rash: ~ Yes ~ No ~ Unk
Health Care Provider:	Altered Mental Status: ~ Yes ~ No ~ Unk	Muscle pain: ~ Yes ~ No ~ Unk
Phone:	Other neurological signs: ~ Yes ~ No ~ Unk	Muscle Weakness: ~ Yes ~ No ~ Unk
Date Reported to Local Health Department::	**Outcome:** **~ Recovered ~ Still ill ~ Deceased ~ Unk**	
	Date of Death:	

LABORATORY INFORMATION

Date Lab Specimen Collected:	Testing Laboratory:
Specimen Source: ~ Blood ~ CSF ~ Other ***(List below)***	IgM: ~ pos ~ neg ~ equiv IgG: ~ pos ~ neg ~ equiv ***(Please attach lab report(s) if available.)***

OUT OF STATE TRAVEL HISTORY

Travel outside Montana 14 days prior to illness onset? ~ Yes ~ No ~ Unk	Location(s):	Dates:

COUNTY HEALTH DEPARTMENT USE ONLY

~ New Case ~ Update of prior report	Out of Jurisdiction Case. Case was: ~ Referred to DPHHS ~ Referred to County of Residence
Comments:	
Local Health Department Reviewer:	Date: